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	175418	A. BUILDING _____ B. WING _____	R 04/16/2014

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PROVIDENCE LIVING CENTER	**1112 SE REPUBLICAN TOPEKA, KS 66607**

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{F 000}	INITIAL COMMENTS The following citations represent the findings of a Non-Compliant Revisit and Complaint Investigation #72260, #73589.	{F 000}		
{F 253} SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: The facility identified a census of 73 residents. Based on observation, record review, and interview the facility failed to maintain a sanitary, orderly, and comfortable environment on 2 of 2 hallways where residents resided and 1 of 1 activity room for 2 of 3 days onsite for the revisit survey. Findings included: - Observation on 4/9/14 from 11:00 A.M. to 11:25 A.M. on the north hallway revealed the following: several resident rooms with peeling paint on the walls of the bedrooms, cracked and stained tiles in the bathrooms, and stained grout in the bathrooms. Observation on 4/9/14 from 11:54 A.M. to 12:15 P.M. on the south hall revealed the following: several resident rooms with chipped or peeling paint on the walls, stains on the walls near the windows and one resident room with toilet bolt covers missing from the toilet base, lack of grout	{F 253}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{F 253}	Continued From page 1 around the base of the toilet, and stained bathroom tiles. Observation on 4/9/14 at 12:36 P.M. of the activity room revealed peeling paint on the wall and potting soil and/or dirt on the window ledge. Observation on the environmental tour with the maintenance staff X on 4/10/14 at 4:15 P.M. through 4:35 P.M. revealed the above findings were unchanged. Interview on 4/10/14 at 4:15 P.M. through 4:35 P.M. with maintenance staff X revealed he/she acknowledged the above mentioned concerns. The facility failed to provide a preventative maintenance policy addressing the above concerns. The facility failed to maintain a sanitary, orderly, and comfortable interior for the residents of the facility.	{F 253}		
{F 323} SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 73 residents.	{F 323}		

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The sample included 12 residents. Based on observation, record review, and interview the facility failed to follow the care plan to prevent falls for 1 (#1) of 3 residents reviewed for accidents.

Findings included:

- The significant change Minimum Data Set 3.0 with an Assessment Reference Date of 1/24/14 revealed resident #1 had a Brief Interview for Mental Status score of 8, indicating moderate cognitive impairment. He/she had hallucinations (sensing things while awake that appear to be real, but instead have been created by the mind) and delusions (an untrue persistent belief or perception held by a person although evidence shows it is untrue), verbal behaviors directed towards others 4 to 6 days of the 7 day look back period that significantly interfered with his/her care, and rejected care daily. The resident required extensive 1 person assistance from staff with transfers, locomotion, dressing, and personal hygiene, and extensive 2 person assistance with walking and toilet use. The resident was not steady and was only able to stabilize with human assistance when moving from a seated to a standing position, walking, turning around and facing the opposite direction while walking, moving on and off the toilet, and with surface-to-surface transfers. He/she had limitations in range of motion in bilateral upper and lower extremities and used a wheelchair. The resident had 2 or more non-injury falls while in the facility since the last assessment or since admission.

The Care Area Assessment for falls dated 2/7/14 revealed the resident was at a high risk for falls

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{F 323}	Continued From page 3	{F 323}		

related to decrease in physical function and noncompliance. He/she used a wheelchair for locomotion, was noncompliant with staff assistance, believed he/she was able to do everything by him/herself with no assistance, transferred with extensive assist by staff, and did not like when staff used a gait belt to assist him/her. Staff educated the resident on use of the gait belt for safety. He/she ambulated with 2 person assistance from staff members due to weakness. Staff educated the resident on use of the call light but refused to use it. The resident continued to attempt to self-transfer, had poor impulse control, and made poor decisions related to safety. Staff attempted to keep the resident safe and free of falls. Staff educated the resident, his/her family, and other staff on his/her safety. When staff redirected or educated the resident, he/she became very aggressive, agitated, and hit staff who attempted to assist him/her.

The fall care plan dated 5/29/13 with a revision date of 4/8/14 revealed the resident was at high risk for falls related to use of psychotropic medications, had decline in physical status, refused assistance, used a wheelchair for mobility, and had a personal history of falls. He/she exhibited poor impulse control, poor safety awareness, was noncompliant with staff assistance, and refused staff assistance after verbalizing understanding on education the facility provided concerning safety awareness and staff encouragement. Staff provided the resident with 15 minute checks indefinitely, 2 person assistance with transfers, a chair alarm when up in chair, anti-skid strips on the floor in the bathroom in front of the toilet, anti-skip strips on the floor by the bed, an auditory monitor in the room to enhance alarm sound at nurse's desk, a

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{F 323}	Continued From page 4	{F 323}		

bed alarm when in bed, a mat on the floor next to the bed when he/she was in bed, grab bars in the bathroom, and the bed in low position. Staff continued to educate about risk for falls and for the resident to call for assistance. Hospice services provided a new wheelchair with a reclining back and cushion.

Observation on 4/10/14 at 12:25 P.M. revealed the resident rested in bed quietly with his/her eyes closed. The bed was in the low position, fall mat in place, bed alarm on, and an auditory monitor on the floor near the head of the bed with no power indicator light lit indicating the monitor was not on.

Observation on 4/10/14 at 1:22 P.M. revealed administrative nursing staff E and direct care staff P assisted the resident to transfer using a gait belt from his/her bed to a wheelchair. The bed alarm did not sound when staff lifted the resident from the bed surface and it was noted the auditory alarm was under the resident's bed but the power indicator light was not lit prior to the transfer.

Interview on 4/10/14 at 1:26 P.M. with administrative nursing staff E revealed the restorative aid checked the functioning of alarms weekly on Fridays. Staff E also stated the auditory monitor was on at all times. Staff E acknowledged the bed alarm failed to sound when the resident stood up during the transfer and the auditory monitor's power indicator light was not on.

Interview on 4/10/14 at 1:38 P.M. with direct care staff Q revealed certified nursing assistants (CNAs) checked the functioning of the bed, chair,

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and auditory alarms. Staff Q reported there was a green light on the auditory alarm box at the nurse's station that verified if the device was on but he/she was unsure of which staff member was responsible to ensure the green light was on.

Interview on 4/10/14 at 1:46 P.M. with licensed nursing staff H revealed whichever staff was working checked the functioning of the alarms each shift. Staff H also reported the auditory alarm was plugged in and on at all times. Staff H stated he/she checked that the auditory alarm was on by hearing what was going on in the resident's room from the box at the nurses' desk. Staff H reported that morning he/she checked the monitor in the resident's room and it was on at approximately 8:00 A.M.

Interview on 4/10/14 at 2:35 P.M. with administrative nursing staff D revealed the restorative aid checked the alarms weekly and kept a log. Staff D reported the CNAs checked the alarms when they applied them and the audible alarms were on at all times. Staff D stated the CNAs performed a visual check when the residents were laid down to make sure the indicator light was on.

The undated policy provided by the facility regarding fall prevention and management revealed nurses were responsible for implementation and oversight of individualized resident fall prevention care. All staff were responsible for implementing the intent and directives contained within this policy and creating a safe environment of care for each resident.

The facility failed to provide interventions as planned for the prevention of falls for this

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{F 323}	Continued From page 6 moderately cognitively impaired resident with a history of falls.	{F 323}		
{F 406} SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Gill, Caryl The facility had a census of 72 residents. The sample included 12 residents. Based upon observation, record review and interview the facility failed to ensure 1 (#27) of 1 resident received specialized rehabilitative services as outlined in the resident's PASRR (Pre-Admission Screening and Resident Review). Findings included: - Resident #27's quarterly Minimum Data Set (MDS) dated 3/7/14 included the resident scored 14 (cognition intact) on the Brief Interview for Mental Status, had hallucinations (sensing things while awake appeared real, but instead were created by the mind) and rejected care 1 to 3 days of the 7 day assessment period. The MDS	{F 406}		

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recorded the resident was independent with bed mobility, required supervision with dressing, toilet use and personal hygiene. The MDS recorded the resident received antipsychotic medication (medication used to treat mental illness) and anti-anxiety medication (medication to manage the symptoms of emotional disorders) 7 of the 7 days and anti-depressant (used to treat a mood disorder that caused a persistent feeling of sadness and loss of interest) medications 6 of the 7 days in the assessment period.

The resident's Mood Care Area Assessment (CAA) dated 12/12/13 documented the resident refused medications at times.

The resident's Antipsychotic CAA dated 12/12/13 documented the resident received psychotropic medications (medication capable of affecting the mind, emotions, and behavior). The resident at times refused medication and was noncompliant when he/she struggled with his/her mental illness and at times was verbally aggressive when cued to take his/her medication.

The resident's care plan with interventions dated 12/27/13 included the resident discussed any medication issues with the psychiatric advance registered nurse practitioner or the facility's medical director to find alternative medications that he/she agreed as appropriate. Social services/nursing met with the resident 1 on 1 to encourage the resident to attend the weekly medication group so staff could inform the resident of his/her medications and the consequences of not taking the medications.

The resident's PASRR dated 11/27/13 included the facility staff to educate the resident regarding

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his/her medication regimen including the reason and the importance of taking the medication.

The resident's clinical record did not support the facility educated the resident regarding his/her medication regimen nor of the reason and the importance of taking the medication.

On 4/10/14 at 9:02 A.M. and 9:18 A.M. the resident sat in an administrative office and performed math problems.

On 4/10/14 at 1:40 P.M. administrative nursing staff D stated each day the charge nurse and the resident reviewed his/her medications, and stated licensed staff M discussed medications and diagnoses with the wellness group.

On 4/14/14 at 8:00 A.M. licensed staff M stated he/she conducted the wellness group. Licensed staff M stated he/she discussed 6 to 7 psychotropic medications with each group and then gave the residents a quiz on the reviewed medications. Licensed staff M stated he/she did not conduct individualized 1 on 1 education with residents regarding his/her medication regimen.

On 4/14/14 at 3:14 P.M. licensed staff M provided the agenda, attendance record and dates of the wellness groups. Review of the information from 2/19/14 to 4/1/14 revealed the resident attended the Crisis Cycle wellness group on 2/12/14 and the Building Relationship wellness group on 2/26/14. Licensed staff M stated he/she conducted the wellness group once or twice a week.

The facility failed to educate the resident on his/her medication regimen as outlined in the

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{F 406}	Continued From page 9 PASRR.	{F 406}		
{F 441} SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	{F 441}		

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This REQUIREMENT is not met as evidenced by:
The facility identified a census of 73 residents. Based on observation, record review, and interview the facility failed to follow their policy for cleaning of 1 of 1 resident rooms.

Findings included:

- Observation on 4/14/14 at 8:55 A.M. revealed housekeeping staff Y cleaned a resident's room and he/she failed to clean and disinfect the call lights, call light cords, bed controls, and bed control cords.

Interview on 4/14/14 at 8:55 A.M. with housekeeping staff Y revealed the call lights and bed controls were only disinfected with the deep cleaning of every room and not included on daily cleanings of resident rooms.

Interview on 4/14/14 at 9:46 A.M. with maintenance and housekeeping staff X revealed housekeeping staff were to disinfect and clean call lights and bed controls with the daily cleanings of each resident room.

Interview on 4/14/14 at 12:04 P.M. with administrative nursing staff D revealed housekeeping staff were to clean and disinfect the call lights and bed controls during daily room cleanings.

Review of the undated daily cleaning log provided by the facility revealed housekeeping staff were to

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{F 441}	Continued From page 11 initial when they completed each task. The call light was included on the checklist. The undated policy provided by the facility regarding appropriate cleaning of a facility resident room and common areas revealed daily staff duties included the cleaning of call lights and other frequently touched areas. The facility failed to clean and sanitize the call light and bed controls during daily resident room cleanings.	{F 441}		
{F 520} SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as	{F 520}		

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{F 520}	Continued From page 12 a basis for sanctions. This REQUIREMENT is not met as evidenced by: The facility reported a census of 72 residents. The sample included 12 residents. Based on observation, record review, and staff interview, the facility Quality Assessment and Assurance (QAA) committee failed to identify and remedy issues that required an action plan. Findings included: - On 4/14/14 at 3:17 P.M. administrative staff A stated the QAA committee met at least quarterly and reviewed weight loss, nutritional status, skin issues, activities, revision of care plan regarding medication changes, falls and reviewed the 2567 (facility survey results). Administrative staff A stated the building maintenance was an on-going process. The facility trained all staff to fill out environmental maintenance forms which notified administration of items that needed fixed and staff monitored the privacy curtains for cleanliness. Administrative staff A stated the facility provided in-services and re-educated staff regarding resident's preferences, dignity and privacy. The QAA Committee monitored to ensure staff obtained laboratory orders in a timely manner. Based on observation, record review, and interview, the facility failed to ensure the facility maintained a sanitary environment. Please see F253 for additional information. Based on observation, record review, and interview the facility failed to provide assistive	{F 520}		

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{F 520}	Continued From page 13 devices/supervision to prevent accidents. Please see F323 for additional information. Based on observation, record review and interview the facility failed to educate a resident on his/her medication regimen as outlines in the Pre-Admission Screening and Resident Review. Please see F406 for additional information. Based on observation, record review and interview the facility failed to ensure call lights and bed controls were disinfected. Please see F441 for additional information. The facility failed to maintain an effective QAA committee that identified areas of concern, planned interventions, and monitored for effectiveness.	{F 520}		